VERMONT

DOL FORM 24 (Rev. 5/05)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

AGREEMENT FOR TEMPORARY PARTIAL DISABILITY COMPENSATION

IT IS AGREED, between _____, the employee, whose mailing address is:

_____

Street, Rural Route, Box Number, City, State, Zip

AND _____ the insurance carrier/employer, that on _____, 20 _____ the employee suffered an accident while in the employ of _____ of the city/town of _____ state of _____ causing the following injury: _____ and resulting in temporary total disability beginning on _____, 20 _____.

WEEKLY COMPENSATION RATE

The employee's average weekly for the twelve weeks before the accident was $ _____ and that he/she has weekly earnings of $ _____ and he/she is entitled to temporary partial compensation of $ _____ per week.

Maximum and minimum weekly compensation rates are set annually by a self-adjusting formula. New rates are effective July 1 of each year and apply to accidents which occur between that date and July 1 of the following year. New rates are adopted and published annually by the Commissioner of Labor during the month of May.

MEDICAL, HOSPITAL AND SURGICAL SERVICES

That the employee shall receive medical, hospital, surgical and nursing services and supplies in accordance with the provision of 21 V.S.A. § 640. The expense of such services and supplies shall be borne by the insurance carrier/employer.

TEMPORARY PARTIAL DISABILITY

Beginning the 8th day of temporary partial disability or at the end of temporary total disability, on the _____ day of _____, 20 _____ the employee shall receive compensation at said temporary partial rate.

APPROVAL AND REVIEW

This agreement or any settlement thereunder shall not be binding or operative unless and until this agreement and such settlement is approved by the Commissioner of Labor, and is subject to review by said Commissioner upon their own motion or on motion of either party upon the ground of a change in physical condition of the employee entitled to compensation hereunder.

_____ Insurance Adjuster Signature

_____ Employee Signature

Date

_____ Official Title

Date

_____ Social Security Number

APPROVED: _____

Date

_____ Commissioner of Labor/Designee